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# UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
# PASRR LEVEL II –
# PREADMISSION SCREENING RESIDENT REVIEW
# FOR SERIOUS MENTAL ILLNESS

## Personal Information

| NAME (LAST, FIRST, MIDDLE) | LEVEL I NUMBER | | SOCIAL SECURITY NUMBER - - | |
|---|---|---|---|---|
| BIRTHDATE (MM/DD/YYYY) | AGE | GENDER | ☐ Female | ☐ Male |

## Type of Assessment

☐ **Initial** ☐ **Pre-Admission** **Reassessment:** ☐ **End of Convalescent** ☐ **Significant Change in Condition**

☐ **Over 30 Day MD Certified Stay** ☐ **NSMI** ☐ **Convalescent Care**

## Referral Information

| INITIAL REFERRAL DATE: | ASSESSMENT START DATE: | DATE MEDICAL/PSYCHIATRIC INFORMATION I.E. HX/PHYSICAL, ORDER, ETC. AVAILABLE: | |
|---|---|---|---|
| REFERRING AGENCY & CONTACT PERSON (PLEASE INCLUDE PHONE NUMBER): | | | |
| Hospital Admission ☐ YES ☐ NO | ADMIT DATE: | DISCHARGE DATE: | **ER ONLY** ☐ YES ☐ NO |
| NAME OF HOSPITAL | | | |

## Facility Information

| NURSING FACILITY | DATE OF ADMISSION: |
|---|---|
| MAILING ADDRESS | |
| ATTENDING PHYSICIAN NAME: (PLEASE PRINT) _____ ☐ Hospital ☐ Nursing Facility | |

## Legal Status

| ☐ Legal Guardian ☐ Legal Representative ☐ Commitment ☐ **Self** | NAME: | PHONE # |
|---|---|---|

| SPOUSE/RELATIVE **(LIST RELATION)** | MAILING ADDRESS | CITY/STATE/ZIP | PHONE # |
|---|---|---|---|
| APPLICANT/RESIDENT AGREES TO LEGAL GUARDIAN/REP. AND/OR FAMILY PARTICIPATION ☐ YES ☐ NO | | TRANSLATOR REQUIRED ☐ YES ☐ NO REASON: NAME : | |

Assessment Completed by: (please print) Credential: Community Mental Health Center:

**MENTAL STATUS EXAMINATION/SUMMARY**

Is Applicant open for mental health services at a Community Mental Health Center: ☐ YES ☐ NO

Name of Community Mental Health Center:

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Comprehensive Mental Health/Substance Abuse & Psychiatric History:

I. Why at Nursing Facility
II. Substance Abuse
III. Psychiatric History
IV. Current Symptoms

V. All psychiatric diagnosis must be based on current Diagnostic and Statistical Manual of Mental Disorders (DSM) Criteria

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Applicant/Resident Name: _____

**MENTAL STATUS EXAMINATION**

**Description:**

Appearance: _____

Attitudes: _____

Overt Behavior: _____

Affect: _____

**Perceptual Disturbances**: (i.e. Psychotic Symptoms)

_____

**Thought Form & Content:** (i.e. linear, logical, tangential)

_____

**Speech Clarity & Modes of Expression:**

_____

**Evaluation of Cognitive Functioning**

**Orientation:** ☐ Person ☐ Place ☐ Situation ☐ Time

**Consciousness:** ☐ Alert ☐ Drowsy ☐ Stupor ☐ Coma

**Judgment:**

| Independent ☐ | Modified Independence ☐ | Moderately Impaired ☐ | Severely Impaired ☐ |
|---|---|---|---|

**Recent Memory:** ☐ **Poor** ☐ Fair ☐ Intact

**Remote Memory:** ☐ **Poor** ☐ Fair ☐ Intact

**Additional Testing Results (if available):** (i.e., Mini Mental Status Exam or other assessment tools. Attach copy behind page 3.)

**Insight** (Knowledge of Illness): ☐ **Poor** ☐ Fair ☐ Good

****Do your findings indicate a likelihood that the applicant may be a substantial danger to himself/herself or others?**

☐ NO ☐ YES **<u>If yes please explain</u>:**

Applicant/Resident Name: _____

**VALIDATION OF APPLICANT/RESIDENT'S**

SERIOUS MENTAL ILLNESS DIAGNOSIS

Based on the data compiled, the following Serious Mental Illness diagnoses are verifiable and indicated based on assessments, evaluations and documentation attached to the PASRR Level II Assessment

| DSM-IV Coding: | Diagnosis Description |
|---|---|
| | |
| | |
| | |
| | |
| | |

Psychiatric medications taken within the last 30 days that could mask or mimic symptoms of mental illness:

| Meds | Dosage | Meds | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Comments/Diagnostic Impressions:

Psychiatric Treatment Recommendations:

M.D. or A.P.R.N. (please print) _____

Signature & Title: _____

If Not Seriously Mentally Ill per state definition, please stop assessment!

Applicant/Resident Name: _____

PSYCHIATRIC SPECIALIZED SERVICES ASSESSMENT

If applicant/resident meets the state definition of SERIOUS MENTAL ILLNESS criteria from Page #4, does the applicant/resident require "In-patient hospitalization for psychiatric specialized services" for the Serious Mental Illness?

☐ YES ☐ NO

***If YES, complete this page. If NO, go to next page.***

If the applicant/resident meets the criteria for "In-Patient Hospitalization for Psychiatric Specialized Services" provide specific summary of the applicant/resident's strengths and weaknesses and the extent to which therapies and activities are required to meet the applicant/resident's SERIOUS MENTAL ILLNESS service needs, regardless of the Nursing Facility's ability to meet those needs:

Psychiatric treatment service needs:

RECOMMENDING DENIAL:

The applicant/resident requires "In-Patient Hospitalization for Psychiatric Specialized Services" for the following Serious Mental Illness Diagnosis:

| DSM-IV Coding | Diagnosis Description | DSM-IV Coding | Diagnosis Description |
|---|---|---|---|
| | | | |
| | | | |

M.D. or A.P.R.N. (please print) _____

Signature: _____ Date: _____

**Please stop assessment if recommending denial!**

Applicant/Resident Name: _____

## SERIOUS MENTAL ILLNESS CRITERIA

483.102(b)(1)(ii)(iii) Definition:

An individual is considered to have a **SERIOUS MENTAL ILLNESS** as defined by the State of Utah, if the individual meets all three of the following requirements: **DIAGNOSIS, LEVEL OF IMPAIRMENT, DURATION OF ILLNESS**

483.102(I)(A)(b) DIAGNOSIS

**Diagnosable under the DSM-IV:**

- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Delusional Disorder
- ☐ Psychosis NOS
- ☐ Depression NOS
- ☐ Major Depression
- ☐ Bipolar Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Panic Disorder
- ☐ Borderline Personality Disorder
- ☐ Somatization Disorder
- ☐ Anxiety Disorder NOS
- ☐ Generalized Anxiety Disorder

483.102(ii)(A)(B)(C) LEVEL OF IMPAIRMENT

Functional limitations in major life activities within the past 3 to 6 months. Must have at **least one** of the following characteristics on a **continuing or intermittent** basis:

**Adaptation to change (serious difficulty)**

- ☐ Adapting to typical changes in circumstances associated with:
  - ☐ Family ☐ School ☐ Social Interaction ☐ Work
- ☐ Exacerbated signs and symptoms associated with the illness
- ☐ Manifests agitation
- ☐ Requires intervention of the mental health or judicial system
- ☐ Withdrawal from the situation

**Concentration, Persistence and pace (serious difficulty)**

- ☐ Difficulties in concentration
- ☐ Inability to complete simple tasks within an established time period
- ☐ Makes frequent errors
- ☐ Requires assistance in completion of these tasks
- ☐ Sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or work-like structured activities occurring in school or home settings

**Interpersonal Functioning (serious difficulty)**

- ☐ Avoidance of interpersonal relationships
- ☐ Communicating effectively with other persons
- ☐ Eviction
- ☐ Fear of strangers
- ☐ Firing
- ☐ Interacting appropriately
- ☐ Possible history of altercations
- ☐ Social Isolation

483.102(iii) (A)(B) RECENT TREATMENT

Document the treatment history which indicates that the individual has experienced at **least one** of the following:

☐ Psychiatric treatment more intensive than outpatient care **more than once** in the past 2 years: (e.g., partial hospitalization/day treatment or in-patient hospitalization; crisis intervention) OR

**Within the last 2 years**

☐ Experienced an episode of significant disruption to the normal living situation:

- ☐ Required supportive services **due to serious mental illness**, to maintain function at home or in a residential treatment environment **OR**
- ☐ Resulted in intervention by housing or law enforcement officials

Applicant/Resident Name: _____

## PSYCHOSOCIAL EVALUATION/SUMMARY

**If available, attach current psychosocial evaluation from the nursing facility and complete the following:

EVALUATION/SUMMARY INCLUDING THE FOLLOWING SPECIFIC INFORMATION:

1. Applicant/Resident place of residence prior to hospital or nursing facility placement:
   - ☐ Home with family support
   - ☐ Home without family support
   - ☐ Assisted Living
   - ☐ Homeless
   - ☐ Other _____

2. Social History (Developmental, Educational, Special Education, Occupational, Marital and Social Supports)

3. Psychosocial Strengths:

4. Psychosocial Weaknesses and Needs:

5. Nursing Facility Admission History:

| Nursing Facility | Admission Date | Discharge Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Applicant/Resident Name: _____

**ATTACH THE FOLLOWING REQUIRED COLLATERAL**

- ☐ Level I Screening Form
  (Required to be completed and signed as indicated prior to PASRR Level II)
- ☐ Physician Orders (Most Current Medication & Treatment Orders)
- ☐ (MDS) Minimum Data Set (if available)
- ☐ (H & P) History & Physical
- ☐ Psychiatric Evaluation (if available)
- ☐ Consultation/Referrals (if available)

**COMPREHENSIVE PHYSICAL EXAMINATION SUMMARY**

PAST MEDICAL HISTORY: (List past Diagnosis, surgeries and medical procedures)

CURRENT MEDICAL DIAGNOSIS:

Applicant/Resident Name: _____

## APPLICANT'S FUNCTIONAL ASSESSMENT

| ACTIVITIES | N/A | SELF INITIATES ADL TASKS INDEPENDENT | SUPERVISION, OVERSIGHT, ENCOURAGMENT OR CUEING | LIMITED ASSISTANCE RECEIVES PHYSICAL HELP (RESIDENT HIGHLY INVOLVED) | EXTENSIVE ASSISTANCE RESIDENT PERFORMED PART OF ACTIVITY | TOTAL DEPENDENCE COMPLETE NON-PARTICIPATION |
|---|---|---|---|---|---|---|
| 1. Toilet Use | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Bladder Continence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Catheter | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Bowel Continence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Locomotion<br>-On unit | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| -Off unit | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Wheelchair/Walker/Cane | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Bed Mobility | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Transfers: One/Two/Weight Bearing | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Verbal/Gestural or Written Communication | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Self-Monitoring of Health Status | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Self Administration of Medication | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Medication Compliance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Self-Directive Accessing Medical Treatment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Eating & Monitoring of Nutritional Status | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Bathing-Personal Hygiene | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Dressing Skills | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Handling of Money | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Source of Information: _____

Applicant/Resident Name: _____

**IDENTIFY THE SPECIFIC NURSING FACILITY SERVICES THAT ARE REQUIRED TO MEET THE APPLICANT/RESIDENT ASSESSED NEEDS**

**The applicant/resident requires medical services and treatment that are intensive and require the support level of nursing facility placement. Check all that apply.**

| | |
|---|---|
| ☐ **Assistance with ADL** | ☐ **Occupational Therapy** |
| ☐ **Catheter Care** | ☐ **Oxygen** |
| ☐ **Colostomy Care** | ☐ **Physical Therapy** |
| ☐ **Feeding Tube** | ☐ **Skin Care** |
| ☐ **V Antibiotics** | ☐ **Speech Therapy** |
| ☐ **Monitor Diet** | ☐ **Wound Care** |
| ☐ **Monitor Medications** | ☐ **Total Care for ADL's** |
| ☐ **Monitor Safety (i.e. falls, wandering risk)** | ☐ **Other** |

**Discharge potential and prognosis for non-institutional residential living arrangements:**

☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

**Could applicant/resident be referred to a home/community based wavier program?** ☐ **YES** ☐ **NO**

**Recommendations & Placements Options:**

**Recommending denial due to absence of medical need:** ☐ Yes ☐ No

Applicant/Resident Name: _____

# PASRR LEVEL II NURSING FACILITY CRITERIA ASSESSMENT

Criteria for Level of Nursing Service for Applicant/Resident with a **SERIOUS MENTAL ILLNESS** as defined by the State of Utah.

The request for nursing facility care must document that the applicant/resident has **TWO or MORE** of the following elements according to Administrative Rule R414-502:

☐ Due to diagnosed medical conditions, the applicant requires at least substantial physical assistance with activities of daily living above the level of verbal promptings, supervising, or setting up;

☐ The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health care delivery program; or
**(Documentation is provided to substantiate significant cognitive deficits – page 7)**

☐ The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting or without the services and supports of an alternative Medicaid health care delivery program.
**(Documentation is provided that less structured alternatives have been explored and why alternatives are not feasible – page 2)**

## DETERMINATIONS

All determinations must verify the existence of a **SERIOUS MENTAL ILLNESS** as defined by the State of Utah and assess the need for specialized services.

☐ Convalescent Care: (an acute physical illness which required prior hospitalization)

☐ Nursing Facility Services (Long Term Care)

☐ Provisional Admission: (Delirium; Adult Protective Services, Emergency) **Prior approval is needed from State MH Authority (DSAMH) BEFORE ADMISSION – Level II is required if provisional admission exceeds 7 days**

☐ Severity of Illness: (Such as: Ventilator, Coma, COPD, CHF, Parkinson's, Huntington's, Amyotrophic Lateral Sclerosis, and functioning at Brain Stem Level) Medical/Physical Fragility: (Level of debilitation is severe and results in a level of impairment deemed not to benefit from mental health services)

☐ Terminal Illness: (Such as: Metastatic CA, Etc.) –Not receiving hospice care

☐ Denial

M.D. or A.P.R.N. (please print) _____

Signature: _____ Date: _____

Assessment Completed by: Credential: Community Mental Health Center:

Signature:

Applicant/Resident Name: _____